Chapter 7

Group Treatment of PTSD and Comorbid Alcohol Abuse

Andrew W. Meisler

Alcohol use disorders are a common and clinically challenging problem among individuals with post-traumatic stress disorder (PTSD). Prevalence estimates of alcohol abuse among trauma victims seeking treatment for PTSD have ranged as high as 75% (e.g., Keane, Gerardi, Lyons, & Wolfe, 1988). Often, these individuals suffer from comorbid anxiety or depressive disorders as well as other substance use disorders, further complicating evaluation and treatment. Yet, only recently have systematic approaches to treatment been developed for these dual disorders. Historically, individuals with PTSD and substance abuse problems were often caught between different treatment systems with different philosophies. Treatment for PTSD in traditional mental health settings was often insensitive to the critical role of alcohol abuse or, worse, was refused because of comorbid substance abuse. Patients would then be referred to substance abuse treatment settings, where the important interplay and overlap of PTSD symptoms and alcohol use was often overlooked. Fortunately, the last 10 to 15 years has seen significant growth in knowledge and clinical application with dually-diagnosed individuals (e.g., Drake & Noordsy, 1996). These approaches emphasize integrated treatment of the whole person, rather than partitioning treatment into separate psychiatric and substance abuse components which often lack continuity of care. It is this integrative approach, in conjunction with mounting experience in applying established substance abuse treatment modalities to individuals with PTSD, that forms the basis for this chapter.

The purpose of this chapter is to describe the principles and techniques of group therapy for individuals with PTSD and comorbid alcohol use disorders. The majority of these techniques share a common cognitive-behavioral basis, an approach justified by the available treatment literature to date in both substance

abuse and PTSD. The reader should be aware at the outset, however, that the majority of techniques covered in this chapter are based on clinical data and experience and relatively little outcome data. Much of this material reflects an integration of material that, until recently, remained largely independent. For example, group treatment has long been the standard of care for patients with alcohol use disorders. Group therapy has also gained prominence in the treatment of PTSD—as this volume attests—though individual approaches still play an important role. The principles and techniques described here reflect a rationally and empirically derived method for integrating these approaches in treating dually-diagnosed individuals. Moreover, this chapter is not a treatment manual that provides detailed instruction on how to deliver treatment. The chapter does, however, provide an overview of concepts and methods sufficient to familiarize the skilled clinician with the essential ingredients of treatment.

The chapter begins with a brief overview of empirical research on PTSD and alcohol comorbidity, including available data on group treatment outcome with this population. The chapter then outlines the fundamental principles and techniques of group therapy, including therapeutic rationale, treatment components, client selection, and troubleshooting.

EMPIRICAL RESEARCH IN PTSD/ALCOHOL ABUSE COMORBIDITY

Both epidemiologic and clinical studies have consistently documented a high prevalence of alcohol abuse in patients seeking treatment for PTSD. For example, in their oft-cited paper, Keane et al. (1988) summarized results of previous studies as well as their own data by suggesting that 60% to 80% of treatment-seeking Vietnam veterans with PTSD also met criteria for current alcohol or drug abuse, or both. More recently, Fontana, Rosenheck, Spencer, and Gray (1995) reported that 44% of veterans seeking outpatient treatment in VA specialized PTSD programs met criteria for alcohol abuse/dependence. Several studies of civilian trauma (e.g., sexual abuse) in treatment-seeking samples also suggest an increased prevalence of alcohol abuse, although these data are less consistent and the prevalence estimates are lower than in veteran samples. Conversely, both clinical and epidemiologic studies of substance abusers have demonstrated a significantly increased risk for both trauma and PTSD (e.g., Cottler, Compton, Mager, Spitznagel, & Ianca, 1992; Fullilove et al., 1993). Thus, just as trauma and PTSD may predispose to substance abuse, the reverse may also be true (for an excellent review of empirical research on PTSD/alcohol comorbidity, see Stewart, 1996).

These high comorbidity rates, in conjunction with the clinical challenge of working with these clients, have led many investigators to speculate about mechanisms of comorbidity. This literature, though limited in scope, has emphasized the role of PTSD symptoms and trauma-related variables in predicting alcohol use.

Abueg and Fairbank (1992) have referred to this as the "interaction argument." Many authors have invoked the concept of self-medication (Khantzian, 1985) as a model for understanding alcohol use in patients with PTSD. This notion is consistent with research on the tension reducing or stress dampening effects of alcohol on anxiety and stress reactivity (e.g., Levenson, Sher, Grossman, Newman, & Newlin, 1980), as well as with other literature on alcohol's effects on cognitive function (see Meisler, 1996a; Stewart, 1996).

A number of studies have yielded data which bear either directly or indirectly on the self-medication hypothesis. Green, Lindy, Grace, and Gleser (1989) found that, among Vietnam combat veterans, exposure to grotesque death (e.g., mutilation) or graves registration, or both, was predictive of alcohol abuse, although the presence of a prewar psychiatric condition also contributed significantly and independently to alcohol abuse comorbidity. In one of the best studies to date, McFall, McKay, and Donovan (1992) examined substance abuse patterns in a sample of 108 combat veterans and 151 noncombat controls. Alcohol and drug abuse was associated with both PTSD severity and combat-related variables. Interestingly, specific PTSD symptom patterns were predictive of substance use patterns; elevated arousal symptoms were associated with alcohol problems, whereas avoidance/numbing was associated with drug abuse. In contrast, epidemiologic data from combat veterans suggested that, although combat exposure was predictive of subsequent substance abuse, PTSD was not (Reifman & Windle, 1996).

An alternative conceptualization is that stress and other trauma-related material may serve as conditioned stimuli or cues for alcohol use. In a recent study, Meisler (1996b) examined the effect of combat cues, noncombat stressful cues, and neutral cues on craving for alcohol in Vietnam veterans with PTSD and alcohol dependence. Consistent with predictions, combat cues elicited the greatest urge to drink, greater even than exposure to alcohol cues in the absence of a stressor. Although further data are needed to clarify the contribution of trauma and PTSD to alcohol abuse, from a clinical perspective the acknowledgment of these factors and the interaction of PTSD and substance use is vital to successful treatment.

As our research base on PTSD and alcohol comorbidity is still in its infancy, so too is the treatment outcome literature. However, several scientist-practitioners have been developing group treatment for this population and have just now begun to report preliminary data on treatment efficacy. For example, Padin-Rivera, Donovan, and McCormick (1996) have developed a 12-week treatment program for veterans with combat-related PTSD and substance use disorders. Although the program is multimodal and includes individual therapy, exercise, and other activities, the core treatment comprises group therapy including educational, skills building, and process components that address PTSD and substance use simultaneously. Initial outcome and preliminary six-month follow-up data based on CAPS

scores are encouraging (Padin-Rivera, Donovan, & McCormick, 1996). Najavits, Weiss, and Liese (1996) describe a manualized 24-session cognitive-behavioral group therapy for women with PTSD and comorbid substance use disorders designed for use in outpatient settings. The treatment also includes education and skills training, with additional emphasis on cognitive restructuring and relationship/communication skills. Preliminary outcome data indicate reductions in both PTSD and substance use at posttreatment and three-month follow-up with good treatment retention and patient satisfaction (Najavits, Weiss, & Shaw, 1996). Further development and evaluation of such treatments is vital if we are to expand our knowledge base and enhance treatment efficacy with this population.

PRINCIPLES AND TECHNIQUES

Therapeutic Rationale

The rationale for the group therapy outlined here comes from several sources. First, group therapy has several advantages over other treatment modalities. For the purpose of education, a group provides the most efficient way to communicate with clients. More importantly, a group of individuals with similar difficulties can provide a supportive and salutary environment for change. Often the knowledge that others share similar experiences and distress is helpful, as clients, prior to entering treatment, often feel isolated, guilty, and misunderstood. Thus the group context provides a safe environment for self-disclosure and reassurance.

Second, there is a strong rationale for treating both disorders together in one group rather than dividing treatments across traditional psychiatric and substance abuse domains. Integration of service improves continuity of care and contributes to clients' perceptions that they are being treated as whole persons. This argument and rationale for integrated treatment is strengthened by the fact that clients often have preconceived beliefs and expectancies about the relationship between PTSD and alcohol abuse. For example, clients often describe their alcohol use as an effort to manage reexperiencing and arousal symptoms of PTSD. Often, these attributions become firmly embedded in a cognitive schema for understanding and explaining their difficulties. Whether these explanations are ultimately true or not, they represent an important part of the client's view of his or her illness, and must be taken into account in treatment. One difficulty often encountered in work with the dually-diagnosed is that psychoeducation about the interaction of PTSD and alcohol use can actually be construed by patients as reinforcing the view that PTSD causes substance abuse, that they are not responsible for change, and that they can only stop drinking when the PTSD is treated or cured. It is therefore imperative for the therapist to emphasize that knowledge and awareness of PTSD/alcohol interactions enhance the patient's ability to manage their disorders more effectively, but do not relieve them of responsibility for change.

The content of group sessions is guided by the observation that PTSD and alcohol dependence do share many common features. First, reexperiencing symptoms, the hallmark of PTSD, are also present—albeit in a slightly different way—in substance use disorders. For example, there is considerable clinical evidence that intrusive thoughts in the form of craving play a strong role in relapse to alcohol (e.g., Marlatt & Gordon, 1985). Related intrusive phenomena include spending considerable time and effort planning drinking, determining how to get a drink, and imagining the act of drinking. Studies in cocaine (Tunis, Dehuehi, & Hall, 1994) and nicotine (Salkovskis & Reynolds, 1994) addiction, that have conceptualized craving as an intrusive thought, have supported the merit of this conceptualization for understanding treatment outcome and relapse. Thus cognitive-behavioral therapy techniques aimed at managing attentional processes are relevant for both PTSD and alcohol dependence. Second, both disorders also share a critical arousal component. The hyperarousal symptoms of PTSD and their neurobiologic substrate have been well documented (see Orr, 1994; Charney, Deutch, Krystal, Southwick, & Davis, 1993). Similarly, research has demonstrated exaggerated arousal in response to alcohol cues in alcoholics (e.g., Cooney, Baker, Pomerleau, & Josephy, 1984; Monti et al., 1987) and a number of studies have linked alcohol to a reduction or *dampening* of the stress response (e.g., Levenson, Sher, Grossman, Newman, & Newlin, 1980). Thus arousal reducing strategies (e.g., anger management or relaxation) are important for both disorders. Third, both PTSD and alcohol dependence share a reliance on avoidant coping strategies. In chronic alcohol dependence and PTSD, more active and problem-focused coping skills atrophy. In some cases, avoidance—in conjunction with alcohol use—often becomes the sole coping strategy. Hence, treatments designed to enhance social problem-solving as well as emotion management are critical for successful treatment.

Client Selection Considerations

There are a variety of client characteristics that impact on treatment. Although few client factors will necessarily preclude participation in treatment, there are a number of considerations that can influence the course and focus of treatment as well as prognosis. Careful assessment of these client factors using both structured interview and paper-and-pencil measures is essential prior to commencing group treatment.

Type of trauma is an obvious consideration in client selection. The treatment outlined in this chapter is based largely on experience with Vietnam combat veterans. However, the techniques are not specific to a particular trauma type. The emphasis here is on symptom profiles in PTSD and alcohol dependence, which can then be customized to suit the needs of the population. It is generally accepted clinically that homogeneous groups foster rapport and facilitate the group therapy

process. Patients with similar trauma histories feel more comfortable discussing trauma-related material, and can provide support to one another that may otherwise be unavailable in a more heterogeneous group. However, just as clients with different addictions can benefit from mixed groups that emphasize commonalities across addictions, so too can PTSD clients with varied backgrounds. Ultimately, selection of clients based on trauma history will depend on the therapist's interest, the clinical demand, and the setting in which the work is done.

Clinicians are often reluctant to treat clients with a history of severe and refractory alcohol dependence or comorbid illicit drug use, or both. Generally, these clients are believed to adhere more poorly to treatment and have higher drop-out and relapse rates. We have found, however, that clients who are ready for change, regardless of history, respond well to the treatment components presented here. In this context it is useful to apply the concept of stages of change (cf. Prochaska & DiClemente, 1982). In this model, readiness for change is viewed as a fluid and changing factor in treatment rather than as a motivational concept or as an enduring part of the person's character. Research on stages of change in alcohol abuse has generally supported four stages: precontemplation, contemplation, action, and maintenance. Regardless of history, clients at the contemplation/action stages are generally ready for the treatment program presented here. Motivational components described below are particularly useful for clients in earlier stages of readiness for change.

One of the most pressing debates and perhaps the most difficult decision to make clinically is whether or not to begin treatment while a client is still actively drinking. Some have argued that substance use must be in remission prior to initiating treatment for PTSD. In fact, active substance use has often been listed as an exclusion for exposure-based PTSD treatment, citing risk of substance abuse exacerbation caused by exposure-induced anxiety and arousal. In contrast, two clinical reports have suggested that such treatment may actually lead to decreased drinking in patients with active alcohol problems (e.g., Keane & Kaloupek, 1982; Lacousiere, Godfrey, & Rubey, 1980). In general, clinicians must weigh the following factors in determining the appropriateness of initiating treatment with active drinkers:

- Has there been a recent exacerbation in frequency and/or severity of alcohol use relative to baseline? Have there been repeated unsuccessful attempts to stop in recent weeks?

- Does drinking serve as potent distractor which will interfere with commitment to treatment, group attendance, homework completion, etc.?

- Can the client set positive and realistic goals for change in drinking behavior and set these as a priority in the treatment?

- Will ongoing drinking have a negative impact on other group members' sobriety and their belief in the integrity of the treatment?

- Consideration of clinician's own model. Those who subscribe to a 12-step approach based on a disease model are less likely to tolerate moderate alcohol use, whereas those with a more behavioral background may view moderate intake as consistent with the notion of *harm reduction.*

Whether one chooses to treat those who are actively using or sets some period of sobriety as a prerequisite, drinking behavior must be monitored carefully and specific goals for drinking behavior must be set. Experience suggests that, for active drinkers who meet criteria for alcohol dependence, an intensive inpatient or partial day treatment program targeting alcohol use is often a good prerequisite or, at least corequisite, for treatment.

Pending disability claims or other litigation (e.g., Social Security or VA disability, worker's compensation, personal injury litigation) often play a role in clients seeking treatment for PTSD. Clinicians often become frustrated with these clients, whom they perceive as seeking treatment for secondary gain and lacking real incentive for change. Nevertheless, these clients can benefit from therapy when clear limits are set and careful treatment planning and goal setting is offered (Meisler, 1995). Other client characteristics that may influence selection and course of treatment include background knowledge and/or treatment of PTSD, comorbid Axis I disorders (e.g., panic, social phobia, major depressive disorder), social supports, and cognitive function. These factors are likely to affect goal setting and pace of progress in treatment.

Inpatient and Outpatient Issues

The treatment program outlined here is designed for use primarily in outpatient settings. As inpatient treatment has increasingly become short-term and crisis-oriented, the focus of treatment must move to outpatient. However, for those who work in acute inpatient settings, the treatment program outlined here can be tailored easily to fit these needs. Two approaches work particularly well. First, after careful assessment of PTSD, substance use, and comorbid disorders, inpatient treatment can focus on many of the earlier stages of treatment, particularly psychoeducation and skill building components. A second and very effective way of applying this program to the inpatient setting is to have multiple groups running at different times or by different therapists, or both. For example, clients may begin in the psychoeducational components of therapy while beginning to learn self-management skills. Such a program would fit very well into many existing substance abuse treatment programs which already incorporate many of the skills components but lack specific PTSD-focused education and treatment. In this way, clients can receive the maximum amount of treatment in what is usually a very

time-limited setting. This also allows clinicians with varying expertise and interest to apply their skills to different components of treatment. If treatment is implemented in inpatient settings, it is vital that a coordinated aftercare plan be in place to continue the work begun during hospitalization. In some settings these services may even be provided by the same clinicians. In most settings, however, some collaborative work will be needed to implement this effectively.

Treatment Phases

The following sections outline and describe the essential components of group therapy with PTSD alcohol abusers. These components can be thought of as stages or phases of treatment, with some materials preceding others in a treatment sequence. In general, psychoeducation provides the cornerstone for the treatment, followed by self-management skills training, social skills training and, in some cases, exposure. Motivational enhancement is also an important component of treatment and is woven throughout the other modules. It is important to recognize that although this outline represents a model for treatment, these stages need not be invariant across settings, client populations, or individuals. Individual assessment will reveal areas of relative strength and weakness of each client vis-à-vis the treatment program. Moreover, although a staged approach to treatment is informed by the transtheoretical model (Prochaska & DiClemente, 1982), the model does not dictate how or in what sequence treatment is provided.

There are several overarching features of treatment which span treatment modules.

- Membership of six to eight clients is ideal, although the group may run with as few as four or as many as ten. Although closed groups facilitate peer support and trust, in many settings therapists may choose to open the group when starting a new module which can be offered on a rotating basis.

- Toxicology screens and breathalyzers should be conducted routinely. Refusal to give a specimen or be breathalyzed must always be interpreted as a positive (i.e., *dirty*) result. Clients are instructed not to come to group intoxicated, and are asked to leave if they do so—as long as it is deemed clinically safe (i.e., the client is not suicidal, or, if grossly impaired, has safe means of transportation).

- Each module and each session begin with a brief check-in to inquire about pressing issues, including suicidality, homicidality, and relapse. Check-in also provides clients the opportunity to discuss homework assignments, address difficulties encountered, and receive feedback.

- Clients are instructed to begin daily home monitoring of drinking behavior in the first week of treatment and continue throughout treatment. Monitoring

itself can reduce drinking behavior, provide important clinical data about triggers and consequences, and provide a measure of outcome.

- Each module begins with a rationale based both on PTSD and alcohol abuse management. Treatment modules may take one session or span multiple sessions, depending on a number of factors, including client selection, overall length of treatment, and therapist preference.

- Each session includes didactic material, discussion, and skill rehearsal.

TREATMENT MODULES

Psychoeducation about PTSD and Alcohol

Education about alcohol, its acute pharmacologic effects and the sequelae associated with long-term use, is important information that must be conveyed early in treatment. Such information is readily available in video, booklet, and through other sources. If in doubt, check with your local substance abuse treatment facility or the National Institute on Alcohol Abuse and Alcoholism.

Education about alcohol's effects on symptoms and functions related to PTSD is particularly important for engagement at this stage of therapy. Many patients seeking treatment for PTSD may minimize the hazards associated with drinking if they are presented without relevant context. Thus, carefully crafted psychoeducation about the interaction between alcohol's effects and PTSD symptoms can be crucial in engaging patients in active treatment, building alliance, and enhancing motivation. Such education, although initiated early in treatment, continues throughout treatment, serving as a factor in ongoing motivational enhancement. Facts about alcohol that are particularly relevant for individuals with PTSD include the following:

- Alcohol is a depressant. Although it may improve mood in the short run, it increases depression associated with PTSD.

- Alcohol interferes with normal sleep cycles. Although it may assist sleep onset and reduce nightmares by reducing REM, it further impairs the body's normal sleep patterns which are already impaired by PTSD. Frequent attempts to abstain from alcohol, characteristic of dependence, can precipitate REM rebound and exacerbate nightmares. Alcohol abuse causes this vicious cycle of PTSD exacerbation.

- Alcohol narrows attention. Although it sometimes aids in blocking out trauma-related thoughts, at other times it can exacerbate reexperiencing symptoms. Discussion of clients' experience with exaggerated intrusive symptoms during intoxication can be prompted here.

- Alcohol use leads to dependence on alcohol for coping with stress in day-to-day life. Alcohol use will interfere with learning and using the tools and strategies needed to cope with PTSD.

- Withdrawal from alcohol mimics PTSD symptoms (anxiety, hypervigilance, startle, sleep disturbance), leading to a vicious cycle (cf. Saladin, Brady, Dansky, & Kilpatrick, 1995). Alcohol withdrawal should not be mistaken for exacerbation of PTSD symptoms. The spiral of PTSD symptoms, alcohol use, alcohol withdrawal, and symptom exacerbation is illustrated in Figure 7.1

- Physiological and biochemical changes resulting from alcohol cessation can persist for months, resulting in disturbances in sleep, appetite, energy, mood and other functions long after detoxification is complete.

The concept that alcohol not only is harmful in and of itself but also exacerbates PTSD is motivating for many patients. However, some patients may deny that they have experienced any of these harmful effects, particularly those in early stages of recovery or those whose alcohol use disorder has been less severe or disabling. Most patients in group, however, will be able to relate to one or more of these facts about alcohol and PTSD. Facilitate discussion by prompting patients for examples from their own experience.

Date/Time	Trigger	Mood	PTSD sxs (1–10) Pre	Alcohol Craving (1–10) Pre	Strategy used	PTSD sxs (1–10) Post	Alcohol Craving (1–10) Post

Figure 7.1. Sample Home Monitoring Form

Sleep Hygiene

Instruction in and discussion of sleep hygiene is an important part of therapy for PTSD substance abusers. Virtually all clients will rate sleep disturbance as a primary complaint, and many have developed maladaptive methods for coping with these disturbances (e.g., drinking to pass out, taking sedative/hypnotic/anxiolytic medications which lead to dependence, altering sleep cycles to sleep during the day when they feel safer). Important elements of sleep hygiene include:

- Establishing a bedtime routine.
- Avoiding caffeinated beverages after 4 p.m.
- Use of warm baths, warm milk, herbal teas.
- Use of white noise.
- Use of night lights. Darkness is often a conditioned stimulus associated with trauma, and can exacerbate disorientation related to nightmares.
- Relaxation procedures (see below).

Motivational Enhancement

Motivation enhancement represents a set of techniques that are used throughout treatment, though their use early in treatment is particularly important. Capitalizing on clients' motivation for change and enhancing that motivation are key ingredients in the early stages of treatment. In contrast to more traditional approaches to treating addictions which rely on confrontation to deal with resistance and motivate clients, more recent approaches have viewed resistance or ambivalence regarding change as normal and as an appropriate target for therapeutic intervention. Miller & Rollnick (1991) describe a variety of strategies and approaches for enhancing motivation for change. Although the emphasis has been primarily on individual interviewing, many of the same principles are readily applied in the group format.

Express Empathy Miller and Rollnick (1991) described empathy as an "essential and defining characteristic" of motivational work. Acceptance and understanding of the client's feelings of distress, reasons for drinking, and ambivalence regarding change are vital in the establishment of rapport and trust which are prerequisites for successful use of therapy. Clinicians who are well-versed in PTSD and knowledgeable about the relationship between PTSD and substance

use can use this knowledge to facilitate change by allowing the client to feel understood. Clients have often been misunderstood by their family, friends, and even themselves. Many are confused or terrified by their symptoms and fear losing control. Empathy helps to validate the client's experience and thereby facilitates change. Carefully drawn comparisons and analogies among group members' experiences can serve to increase this feeling of understanding, though care must be taken not to exaggerate similarities the client may not see and thereby have the opposite effect.

Develop Discrepancy Once empathy is established, discrepancy is used in place of direct confrontation. In developing discrepancy, contrasts are drawn between where persons are and where they have stated they want to be. Most clients seeking treatment already perceive the discrepancy; it is often what has led them to therapy in the first place. The clinician amplifies this discrepancy and in doing so increases incentive for change.

Avoid Argumentation Traditional substance abuse approaches emphasize clients' acceptance of labels such as *alcoholic.* Motivational enhancement approaches avoid confrontation over labels. This principle is particularly important for individuals with PTSD, who often feel the need to control some aspect of their life. Ironically, while many clients may resist the label of alcoholism, a diagnosis of PTSD is often readily accepted, as it provides a schema for understanding their difficulties and can be reassuring. In either case, argumentation over diagnoses, need for treatment, or other issues is counterproductive. The emphasis must be on creating a collaborative spirit in treatment.

Roll with Resistance Miller and Rollnick (1991) discuss the motivational "judo" that is often helpful in enhancing incentive for change. Resistance and ambivalence regarding change are common and natural, and do not necessarily reflect deep-rooted conflicts. Resistance to change is reflected in many forms in group work with PTSD alcohol abusers, including argumentation, externalization and blame, pessimism, and frank denial. By using empathy and discrepancy along with other techniques (e.g., amplified reflection, reframing), such change-resisting behaviors and the motives that drive them can be minimized and the energy behind them can be converted to more positive, change-enhancing behaviors.

Support Self-Efficacy Bolstering self-efficacy is essential if change is to occur. Clients may perceive there is a problem and be made aware of strategies for change, but belief in their own ability to carry out change is a key to success. Very often clients "fail" in therapy because they perceive the demands of treatment to be too great. They lack the confidence in their capacity to do the homework, practice the skills, and face their traumatic history, especially without the cushion of alcohol.

Little has been written about the use of motivational techniques such as these in a group therapy format. Most often, these strategies have been employed in the early stages of individual assessment and treatment planning. However, motivational techniques are vital in dealing with ambivalence that surfaces and resurfaces throughout the course of therapy.

Self-Management Skills

Self-management skills comprise the group of skills and tools individuals use to manage their emotional and behavioral responses to internal and external stimuli.

Problem-Solving Individuals with comorbid PTSD and alcohol use disorders frequently lack the skills needed to solve everyday problems of living. Often these deficits develop over time as a function of reliance on avoidant coping strategies associated with both PTSD and substance use. Fear, anxiety, isolation, and depression associated with PTSD further erode problem-solving skills. Problem-solving training in a group therapy format has been shown to be effective in treating other psychiatric patients with substance use disorders (e.g., Carey, Carey, & Meisler, 1990), and it has been emphasized as an important component in therapy with substance abusing PTSD patients in a VA hospital (Abueg & Fairbank, 1992). Problem-solving therapy involves teaching clients a systematic method for identifying and addressing problems in their lives by dividing the process into five distinct components, based on D'Zurilla (1986). These are: problem recognition (acknowledging there is a problem); problem identification (specifying the problem); generating solutions (brainstorming); evaluating alternative solutions (weighing the pros and cons of each); and implementing a plan of action. Each component is introduced and discussed. At each stage of the process, sample problems and problems from clients' own experiences are used for practice of the problem-solving steps. Therapist skill is important here in facilitating problem-solving by guiding appropriate framing and definition of problems. Often, clients will offer problems that appear insurmountable and then use this as a rationale for discounting "problem-solving" as ineffective. For example, the client who states that her problem revolves around her abusive relationship with a partner and her lifelong feelings of low self-worth should be coaxed to reframe the problem into smaller, bite-size chunks which can then be processed. Reframing of problems into manageable pieces and facilitation of brainstorming alternative solutions is critical to problem-solving work with this population. Once action plans are established, supporting self-efficacy to carry out plans and assess outcomes is accomplished through group support and feedback.

Relaxation Skills Relaxation skills are an important part of self-management in any stress or anxiety disorder. Clients are first provided with information about the fight or flight reaction and the physical, cognitive, and emotional ef-

fects of chronic hyperarousal. Information about catecholamine alterations in PTSD are also discussed, and clients are asked to discuss ways in which they can tell when they are becoming hyperaroused (e.g., physical sensations). The procedure itself is modeled after the progressive relaxation techniques described by Bernstein & Borkovec (1973). Clients are instructed in the three essential components of relaxation training in sequence. First, diaphragmatic breathing skills are demonstrated and practiced. Second, clients are instructed in progressive muscle relaxation using a seven-muscle-group protocol: forehead; mouth and chin; neck, back, shoulders; legs (nondominant, dominant); arms (nondominant, dominant). Finally, a significant amount of time is spent discussing positive relaxing imagery, including creating safety imagery and dealing with negative or traumatic imagery if it occurs during relaxation. Because the perception of loss of control associated with relaxation can be particularly distressing for clients with PTSD, careful attention is paid to increased feelings of vulnerability among group members, and strategies for remaining in control while permitting relaxation are emphasized. Clients are given tapes and encouraged to practice relaxation skills daily at home.

Anger Management Irritability, anger, and outright rage are frequent and extremely disabling arousal symptoms of PTSD. Anger also plays a role in many alcohol relapse situations (Marlatt & Gordon, 1985). For many clients with PTSD, anger is experienced as an automatic reaction to a variety of events. This can be explained in part by conditioned arousal reactions to threatening stimuli. This poses a challenge to the cognitive model of anger proposed in many therapies, in which the connection between events and behavior is mediated by thoughts and beliefs. Therefore, treatment must emphasize the importance of stress reducing relaxation procedures. A threshold model is used to help explain the importance of keeping arousal below the boiling point. By slowing down such reactivity, intervention becomes possible. Clients are first asked to discuss examples of angry behavior and of ways in which anger and aggression has caused problems in their lives. The positive, life-protecting effects of anger are also discussed, with reemphasis of the fight or flight response discussed previously. Clients are introduced to the concept of triggers, and discuss anger triggers in their lives. They are instructed to keep a log of anger situations, the triggers, and both internal (e.g., tension, confusion) and external (e.g., arguments, isolation) consequences. Short-term cooling off strategies are discussed and practiced. Clients are given sample conflict situations as well as examples from their own experience, and group members role play with an emphasis on shaping and guiding anger management strategies.

Self-Reinforcement As avoidance and alcohol use have replaced many other activities, dually-diagnosed clients often have lost ability to reward themselves for progress they have made, especially without alcohol. Feelings of guilt and anhedonia often interfere. However, as patients gain sobriety and increase coping

skills, their ability to reward themselves becomes crucial to increased independence and decreased reliance on alcohol. Exploration of activities and things clients find rewarding is accomplished through discussion. Lists of possible activities can be provided to clients, and assistance in engaging in these activities is offered. Money saved from abstinence from alcohol can be put toward desired things or activities. Occasionally, client consultation with recreation specialists to identify and explore these options is useful.

Cognitive Refocusing Traumatized clients often find it nearly impossible to distract themselves and refocus when they are having intrusive thoughts and when urges to use alcohol are strong. Symptoms of PTSD can serve as cognitive blinders, narrowing attention onto negative aspects of experience and preventing an adaptive shift in attention. Paradoxically, alcohol use in these conditions may actually accentuate this negative focus (Sayette, Wilson, & Carpenter, 1989). Strategies designed to assist clients in refocusing include traditional thought-stopping techniques, as well as techniques derived from Eastern philosophies, including mindfulness meditation. Linehan (1993) provides a variety of useful "grounding strategies" developed for work with borderline clients, and many transfer well to work with PTSD substance abusers.

Social Skills Training

Social skills comprise the group of skills and behaviors that facilitate interaction with the world in a positive and productive way. Many of these skills are derived from the skills training work with alcohol abusers (e.g., Monti, Abrams, Kadden, & Cooney, 1989). For the dually-diagnosed client, the critical skills that are often lacking revolve around assertiveness and availing themselves of social support. In these modules, the concept is introduced by prompting discussion of situations in which group members may have had difficulty in this type of situation. The rationale for the skill is discussed, instruction is provided, and role play and rehearsal is used to practice and refine the skills.

Assertiveness Assertiveness is a fundamental skill needed to successfully maintain sobriety. Dually-diagnosed clients often vacillate between avoidance and passivity on the one hand and anger and rage on the other. The topic is introduced by having the group discuss the difference between assertiveness and aggression. Other communication styles, such as passive and passive-aggressive styles, are introduced and discussed. The advantages of assertiveness in gaining control of one's life are discussed. Specific components of assertiveness, such as specificity, directness, and body language are discussed, and the skills are practiced and role played in group. Importantly, individual client barriers to implementing these skills are assessed and discussed in order to facilitate generalization beyond the group.

Drink Refusal Skills Invitations to drink are inevitable. The ability to refuse such offers is important, particularly in the early stages of sobriety when individuals are highly vulnerable to slips and relapse. As Monti and colleagues (1989) point out, refusal of such offers requires more than simply the desire not to drink; it requires the specific assertiveness skills to carry out that refusal. Clients discuss situations they have encountered or might anticipate in the near future. Drawing on skills learned in the assertiveness module, strategies of saying "no," offering alternatives, and avoiding excuse making are discussed, rehearsed, and role-played.

Receiving Criticism Clients with PTSD and alcohol problems often respond to criticism with hurt, shame, defensiveness, and anger. Constructive criticism may be perceived as destructive, particularly during active drinking phases. Distinguishing between these types of criticism is reviewed, and clients discuss examples from their experience.

Seeking and Accepting Social Support Social support is a critical element in achieving sobriety and facing PTSD-related difficulties. For many clients, however, social supports have dwindled as a result of social avoidance, isolation, and drinking. For some, receiving social support may seem threatening, eliciting feelings of vulnerability, guilt, or resentment. Therefore, the module should start with a discussion of existing social supports and perceived barriers to support, including personal, interpersonal, and environmental factors. Different types of support are discussed, such as practical, financial, moral, and so on. As the importance of social support is recognized and discussed, clients begin to identify ways to form and maintain supports. These include broadening networks (e.g., AA), using assertiveness skills to request support when needed, and learning basic communication and support skills of one's own that are instrumental in establishing supportive relationships.

Relapse Prevention

A great deal has been written on the topic of relapse prevention (e.g., Marlatt & Gordon, 1985). It is an integral part of all cognitive-behavioral treatment programs for substance abuse, and the application of the techniques to individuals with PTSD and comorbid substance use disorders has been well described (e.g., Abueg & Fairbank, 1992). Many of the coping skills needed for effective relapse prevention have already been covered in earlier phases of treatment, as have triggers related to moods and PTSD symptoms that can lead to alcohol use. Thus, during this phase, the focus is on integrating this material and applying it through role play, homework assignments, and group discussion to foster a greater understanding and greater self-efficacy in implementing the knowledge and skills learned. Continued home-monitoring, such as daily use of the chart in Figure 7.2,

can assist clients in identifying the way PTSD symptoms might contribute to relapse and how to best use strategies for managing these triggers.

Direct Therapeutic Exposure

It has long been recognized that exposure-based therapies are the treatment of choice for most anxiety disorders, particularly simple phobias and obsessive-compulsive disorder. Studies of exposure treatment for PTSD have also been encouraging (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Keane, Fairbank, Caddell, & Zimering, 1989). Moreover, alcohol researchers have found exposure therapy to be useful in treating addictions by combining extinction-based procedures with coping skills training (Monti et al., 1993). However, only now is systematic investigation under way to examine the utility of exposure work in the context of group therapy for PTSD (Friedman & Schnurr, 1997), and to date no reports of group exposure work with substance abusers is available. In fact, substance use is often cited as an exclusion for exposure work (e.g., Litz, Blake, Gerardi, & Keane, 1990). Nevertheless, given the association of trauma and alcohol cues in the dually-diagnosed, an exposure therapy that incorporates both types of cues merits investigation. Clinically, these concepts can be applied in the later phases of treatment by having group members engage in imaginal exposure of high risk scenes including both trauma and alcohol cues and using various skills learned in treatment to reduce subjective distress and craving. Repeated guided covert exposure to these cues can result in reduced arousal, reduced craving, and increased self-efficacy.

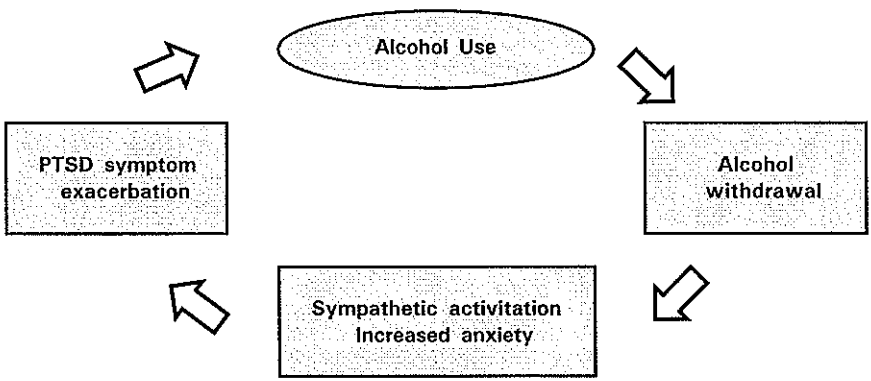

Figure 7.2. Cycle of PTSD and Alcohol Withdrawal

Additional Treatment Components

For many clients, group therapy will be more effective as part of a comprehensive treatment package. For example, AA meetings can provide additional support and encouragement in achieving and maintaining sobriety, although a number of clients with PTSD may find certain aspects of AA philosophy troubling (Satel, Becker, & Dan, 1993). Individual, couples, or family therapy, or both, may also be necessary in addition to group treatment. Involvement in these therapies should not be exclusions for group participation provided that communication between group therapists and other treaters is open and opportunities for splitting and fractionation of care are minimized. Pharmacologic management is likely to be useful, particularly for depressed clients who find participation in group work and homework assignments overwhelming. The use of antabuse and naloxone/naltrexone can also provide important adjuncts to group treatment.

CONCLUSION

Group therapy for individuals with PTSD and comorbid alcohol use disorders is an exciting and important treatment modality. Development and empirical validation of these approaches are in their infancy, and much additional work is needed. Although many of the techniques described here have been used with other clinical populations (e.g., substance abusers), their application and refinement with the dually-diagnosed represents an important advance. Use of these modalities in conjunction with the collection of process and outcome data will enhance our ability to deliver effective group therapy for individuals with PTSD and alcohol use disorders.

REFERENCES

Abueg, F. R., & Fairbank, J. A. (1992). Behavioral treatment of post-traumatic stress disorder and co-occurring substance abuse. In P. A. Saigh (Ed.), *Post-traumatic stress disorder: A behavioral approach to assessment and treatment.* Boston: Allyn & Bacon.

Bernstein, D. A., & Borkovec, T. D. (1973). *Progressive relaxation training.* Champaign, IL: Research Press.

Carey, M. P., Carey, K. B., & Meisler, A. W. (1990). Training mentally ill chemical abusers in social problem-solving. *Behavior Therapy, 21,* 511–518.

Charney, D. S., Deutch, A. Y., Krystal, J. H., Southwick, S. M., & Davis, M. (1993). Psychobiologic mechanisms of post-traumatic stress disorder. *Archives of General Psychiatry, 50,* 294–305.

Cooney, N. L., Baker, L. H., Pomerleau, O. F., & Josephy, B. (1984). Salivation to drinking cues in alcohol abusers: Toward the validation of a physiological measure of craving. *Addictive Behaviors, 9,* 91–94.

Cottler, L. B., Compton, W. M., Mager, D., Spitznagel, E. L., & Janca, A. (1992). Post-traumatic stress disorder among substance users from the general population. American *Journal of Psychiatry, 149,* 664–670.

Drake, R. E., & Noordsy, D. L. (1996). Case management for people with coexisting severe mental disorder and substance use disorder. In N. Miller (Ed.), *Addiction psychiatry.* New York: W. B. Saunders.

D'Zurilla, T. J. (1986). *Problem-solving therapy: A social competence approach to clinical intervention.* New York: Springer.

Foa, E. B., Rothbam, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive–behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59,* 715–723.

Fontana, A., Rosenheck, R., Spencer, H., & Gray, S. (1995). *The long journey home IV: The fourth progress report on the department of veterans affairs specialized PTSD programs.* West Haven, CT: Department of Veterans Affairs, Northeast Program Evaluation Center.

Friedman, M. J., & Schnurr, P. P. (1997). *Department of Veterans Affairs VA cooperative study #420: Group treatment of PTSD.* White River Junction, VT: National Center for PTSD.

Fullilove, M. T., Fullilove, R. E., Smith, M., Winkler, K., Michael, C., Panzer, P. G., & Wallace, R. (1993). Violence, trauma, and post-traumatic stress disorder among women drug users. *Journal of Traumatic Stress, 6,* 533–543.

Green, B. L., Lindy, J. D., Grace, M. C., & Gleser, G. C. (1989). Multiple diagnoses in posttraumatic stress disorder: The role of war stressors. *Journal of Nervous and Mental Disease, 177,* 329–335.

Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. *Behavior Therapy, 20,* 245–260.

Keane, T. M., Gerardi, R. J., Lyons, J. A., & Wolfe, J. (1988). The interrelationship of substance abuse and post-traumatic stress disorder: Epidemiological and clinical considerations. In M. Galanter (Ed.), *Recent developments in alcoholism* (vol. 6). New York: Plenum.

Keane, T. M., & Kaloupek, D. G. (1982). Imaginal flooding in the treatment of posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 50,* 138–140.

Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry, 143,* 1259–1264.

Lacousiere, R. B., Godfrey, K. B., & Ruby, L. M. (1980). Traumatic neurosis in the etiology of alcoholism: Vietnam combat and other trauma. *American Journal of Psychiatry, 137,* 966–968.

Levenson, R. W., Sher, K., Grossman., L., Newman, J., & Newlin, D. (1980). Alcohol and stress response dampening: Pharmacological effects, expectancy, and tension reduction. *Journal of Abnormal Psychology, 89,* 528–538.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder.* New York: Guilford.

Litz, B. T., Blake, D. D., Gerardi, R. G., & Keane, T. M. (1990). Decision making guidelines for the use of direct therapeutic exposure in the treatment of post-traumatic stress disorder. *Behavior Therapist, 13,* 91–93.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford.

McFall, M. E., McKay, P. W., & Donovan, D. M. (1992). Combat-related post-traumatic stress disorder and severity of substance abuse in Vietnam veterans. *Journal of Studies on Alcohol, 53,* 357–363.

Meisler, A. W. (1995, September). Disability benefits and the clinician: Problems and challenges. In S. W. Southwick (Chair), Do *disability benefits make patients sicker?* New Haven, CT: Yale University School of Medicine.

Meisler, A. W. (1996a). Trauma, PTSD, and substance abuse. *PTSD Research Quarterly, 7*(4), 1–6.

Meisler, A. W. (1996b, November). PTSD and substance abuse in Vietnam combat veterans: Behavioral theroy, research, and practice. Paper in L. M. Najavits (Chair), *Post-traumatic*

stress disorder and substance abuse: New clinical frontiers. Symposium presented at the annual meeting of the International Society for Traumatic Stress Studies, San Francisco, CA.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behaviors.* New York: Guilford.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence.* New York: Guilford.

Monti, P. M., Binkoff, J. A., Abrams, D. B., Zwick, W. R., Nirenberg, T. D., & Liepman, M. R. (1987). Reactivity of alcoholics and nonalcoholics to drinking cues. *Journal of Abnormal Psychology, 96,* 122–126.

Monti, P. M., Rohsenow, D. J., Rubonis, A. V., Niaura, R. S., Sirota, A. D., Colby, S. M., Goddard, P., & Abrams, D. B. (1993). Cue exposure with coping skills treatment for male alcoholics: A preliminary investigation. *Journal of Consulting and Clinical Psychology, 61,* 1011–1019.

Najavits, L. M., Weiss, R. D., & Liese, B. S. (1996). Group cognitive-behavioral therapy for women with PTSD and substance use disorder. *Journal of Substance Abuse Treatment, 13,* 13–22.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1996, November). Outcome of a new manualized cognitive-behavioral therapy for women with PTSD and substance abuse. In L. M. Najavits (Chair), *Post-traumatic stress disorder and substance abuse: New clinical frontiers.* Symposium presented at the annual meeting of the International Society for Traumatic Stress Studies, San Francisco.

Orr, S. (1994). An overview of psychophysiological studies of PTSD. *PTSD Research Quarterly, 5*(1), 1–7.

Padin-Rivera, E., Donovan, B. S., & McCormick, R. A. (1996). *Transcend: A treatment program for veterans with post-traumatic stress disorder and substance abuse disorders.* Unpublished document, VA Medical Center, Cleveland, OH.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, and Practice, 19,* 276–288.

Reifman, A., & Windle, M. (1996). Vietnam combat exposure and recent drug use: A national study. *Journal of Traumatic Stress, 9,* 557–568.

Saladin, M. E., Brady, K. T., Dansky, B. S., & Kilpatrick, D. G. (1995). Understanding comorbidity between PTSD and substance use disorders: Two preliminary investigations. *Addictive Behaviors, 20,* 643–655.

Salkovskis, P. M., & Reynolds, M. (1994). Thought suppression and smoking cessation. *Behaviour Research and Therapy, 32,* 193–201.

Sayette, M. A., Wilson, G. T., & Carpenter, J. A. (1989). Cognitive moderators of alcohol's effects on anxiety. *Behaviour Research and Therapy, 27,* 685–690.

Satel, S. L., Becker, B. R., & Dan, E. (1993). Reducing obstacles to affiliation with Alcoholics Anonymous among veterans with PTSD and alcoholism. *Hospital and Community Psychiatry, 44,* 1061–1065.

Stewart, S. H. (1996). Alcohol abuse in individuals exposed to trauma: A critical review. *Psychological Bulletin, 120,* 83–112.

Tunis, S. L., Deluchi, K. L., & Hall, S. M. (1994). Assessing thoughts about cocaine and their relationship to short-term treatment outcome. *Experimental and Clinical Psychopharmacology, 2,* 184–193.